Policy Number	**SUR716.012**
Policy Effective Date	**01/01/2026**

Reduction Mammaplasty for Breast-Related Symptoms

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Related Policies (if applicable)
SUR717.001: Gender Assignment Surgery and Gender Reassignment Surgery and Related Services
SUR716.001: Cosmetic and Reconstructive Procedures

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery and Related Services.

Reduction mammaplasty for symptomatic breast hypertrophy or macromastia **may be considered medically necessary** to reduce the size of the breasts and help ameliorate symptoms caused by hypertrophy when:

1. The surgeon's estimate of breast size/weight/volume to be removed is proportional to the body surface area (BSA) per the Schnur scale (See Policy Guidelines) per breast to relieve symptoms; AND
2. There is presence of shoulder grooving or skin irritation (e.g., areas of excoriation and breakdown) by appropriate supporting garment; AND
3. The patient has significant symptoms, documented in their medical records, that interfere with activities of daily living despite at least 6 weeks of conservative management (see Policy Guidelines), including but not limited to, the following:

- Pain in the upper back, neck, and/or shoulders that appears to be directly correlated to the patient's macromastia,
- Upper extremity paresthesia (e.g., pain and/or numbness in the arms and/or hands) due to brachial plexus compression syndrome secondary to the weight of the breasts being transferred to the shoulder strap area; or

4. Intertriginous maceration or infection of the inframammary skin (e.g., hyperpigmentation, bleeding, chronic moisture, and evidence of skin breakdown), refractory to dermatologic measures.

Reduction mammaplasty **is considered not medically necessary** for all other indications not meeting the above criteria.

EXCEPTION: This policy does not address the performance of a staged reduction mammaplasty preceding a nipple sparing mastectomy or lumpectomy for breast cancer to preserve the viability of the nipple.

Policy Guidelines

Special Comment Regarding Cosmetic Services: Many contracts have exclusions for services or supplies provided for cosmetic procedures. For example, the following services would not be covered for a cosmetic breast reduction (unilateral or bilateral) which is **unrelated** to post mastectomy reconstruction with contralateral breast surgery, post accidental injury or trauma:

1. Diagnostic evaluation of, or
2. Preparation for, or
3. Conjunction with, or
4. Treatment of breast hypertrophy or macromastia.

Medical Necessity Documentation Requirements: **ALL** requests seeking coverage of reduction mammaplasty must include all required documentation before a medical necessity determination can be made.

Photo Documentation Requirements: Photo documentation that is consistent with the physical exam findings of breast hypertrophy and shoulder grooving.

NOTE 1: See Medical Policy SUR716.001 Cosmetic and Reconstructive Procedures for treatment of congenital breast asymmetry.

Conservative treatment may include, but it not limited to, appropriate support bra, exercises, heat/cold treatment, and appropriate nonsteroidal anti-inflammatory agents or muscle relaxants.

Schnur Sliding Scale

Schnur et al. (1991) at the request of third-party payers, developed a sliding scale (Schnur Sliding Scale; SSS). (10) This scale was based on survey responses from 92 of 200 solicited plastic surgeons, who reported the height, weight, and amount of breast tissue removed from each breast. These responses were from the last 15 to 20 reduction mammaplasties they had performed. Surgeons were also asked if the procedures were performed for cosmetic or medically necessary reasons. The data were then used to create a chart relating the body surface area (BSA), and the cutoff weight of breast tissue removed that differentiated cosmetic and medically necessary procedures. Based on their estimates, those with a breast tissue removed weight above the 22nd percentile likely had the procedure for medical reasons, while those below the 5th percentile likely had the procedure performed for cosmetic reasons; those falling between the cut points had the procedure performed for mixed reasons.

Schnur (1999) reviewed the use of the sliding scale as a coverage criterion and reported that, while many payers had adopted it, many had also misused it. (11) Schnur pointed out that if a payer used weight of resected tissue as a coverage criterion, then if the weight fell below the 5th percentile, the reduction mammaplasty would be considered cosmetic; if above the 22nd percentile, it would be considered medically necessary; and if between these cutpoints, it would be considered on a case-by-case basis. Schnur also questioned the frequent requirement that an individual is within 20% of their ideal body weight. While weight loss might relieve symptoms, durable weight loss is notoriously difficult and might be unrealistic in many cases.

PG Table 1. Schnur Sliding Scale

Body Surface Area in Meters squared (m^2)	**Breast Weight in Grams (gm) at the 22^{nd} percentile**
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370
1.75	404
1.80	441
1.85	482
1.90	527
1.95	575
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978

2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

Calculation of Body Surface Area (BSA), as shown in the following (using centimeters for height and kilograms for weight):

1. BSA = the square root of ([height x weight] ÷ 3600).
2. To convert pounds to kilograms, multiply pounds by 0.4536.
3. To convert inches to centimeters, multiply inches by 2.54.

NOTE 2: Claims are subject to review for the actual amount of breast tissue removed. The final coverage determination may be based on a post-operative pathology report confirming the amount and type of breast tissue resected and that this amount is greater than the 22nd percentile of the SSS nomogram based upon the patient's pre-operative BSA and that the tissue removed consisted of breast and not adipose or fatty tissue.

NOTE 3: Tissue removed that plots between the 5th and 22nd percentile of the Schnur Sliding Scale may be either cosmetic or reconstructive. Determination will be based on the review of the information provided.

Description

Macromastia

Macromastia, or gigantomastia, is a condition that describes breast hyperplasia or hypertrophy. Macromastia may result in clinical symptoms such as shoulder, neck, or back pain, or recurrent intertrigo in the mammary folds. Also, macromastia may be associated with psychosocial or emotional disturbances related to the large breast size.

Treatment

Reduction mammaplasty is a surgical procedure designed to remove a variable proportion of breast tissue to address emotional and psychosocial issues and/or to relieve the associated clinical symptoms.

While literature searches have identified many articles that discuss the surgical technique of reduction mammaplasty and have documented that reduction mammaplasty is associated with relief of physical and psychosocial symptoms, (1-9) an important issue is whether reduction mammaplasty is a functional need or cosmetic. For some patients, the presence of medical indications is clear-cut: clear documentation of recurrent intertrigo or ulceration secondary to shoulder grooving. For some patients, the documentation differentiating between

a cosmetic and a medically necessary procedure will be unclear. Criteria for medically necessary reduction mammaplasty are not well-addressed in the published medical literature.

Regulatory Status
Reduction mammaplasty is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

Rationale

Medical policies assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function, including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Reduction Mammaplasty for Macromastia-Efficacy in Reducing Symptoms
Clinical Context and Therapy Purpose
The purpose of reduction mammaplasty is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as nonsurgical treatment, in individuals with symptomatic macromastia.

The following PICO was used to select literature to inform this policy.

Populations
The relevant population of interest is individuals with symptomatic macromastia, or gigantomastia, a condition that describes breast hyperplasia or hypertrophy.

Interventions

The therapy being considered is reduction mammaplasty, a surgical procedure that removes a variable proportion of breast tissue to relieve the associated clinical symptoms and address emotional and psychosocial issues related to large breast size.

Comparators
Comparators of interest include nonsurgical treatment which primarily involves analgesia, clothing modifications, physical therapy and other measures to address symptoms.

Outcomes
The general outcomes of interest are symptoms and functional outcomes. Symptoms of symptomatic macromastia can include mastalgia, pain in the shoulders, back, and neck, or recurrent intertrigo in the mammary fold. The condition may also be associated with psychosocial or emotional disturbances.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs.
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess longer term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Systematic Reviews
Lin et al. (2021) conducted a systematic review of 7 RCTs (N=285) comparing reduction mammaplasty with a control intervention (nonoperation or physiotherapy exercises) for the treatment of breast hypertrophy. (12) Four RCTs were included in meta-analyses reporting on change in pain, physical function, and psychological function after interventions. Statistically significant improvements were found in pain (standardized mean difference [SMD], -1.29; 95% confidence interval [CI], -1.63 to -0.96; p<.00001), physical function (SMD, 0.97; 95% CI, 0.69 to 1.25; p<.00001), and psychological function (SMD, -0.79; 95% CI, -1.07 to -0.52; p<.00001) after mammaplasty compared to the control intervention. The authors concluded that mammaplasty had a positive and significant effect on health-related quality of life, including pain, physical, and psychological functioning, in individuals with breast hypertrophy.

Table 1. RCTs Included in SR & M-A

Trial	Lin et al. (2021) (12)
Beraldo et al. (2016) (13)[a]	●
Iwuaguwu et al. (2006) (6)	●
Iwuaguwu et al. (2006) (14)[a]	●
Freire et al. (2007) (15)[a]	●
Saariniemi et al. (2008) (9)	●

Saariniemi et al. (2009) (16)	●
Sabino Neto et al. (2008) (7)[a]	●

MA: meta-analyses; RCTs: randomized controlled trials; SR: systematic reviews.
[a] Included in M-A.

Table 2. SR & M-A Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Lin et al. (2021) (12)	2006-2016	7[a]	Individuals with breast hypertrophy (mean age, 32 to 46.4 years) receiving either reduction mammaplasty or control intervention (nonoperation or physiotherapy exercises, concentrating mostly on the upper body)	285 (56 to 92)	RCT	4 to 7.8 months

MA: meta-analyses; RCTs: randomized controlled trials; SR: systematic reviews.
[a] Only 4 included in M-A.

Table 3. SR & M-A Results

Study	Change in Pain from Baseline	Improvement in Physical Function from Baseline	Change in Psychological Function from Baseline
Lin et al. (2021) (12)			
Total N	165 (2 studies)	221 (3 studies)	221 (3 studies)
SMD (95% CI)	-1.29 (-1.63 to -0.96)	0.97 (0.69 to 1.25)	-0.79 (-1.07 to -0.52)
p-value	<.00001	<.00001	<.00001
I^2 (p)	34% (.22)	42% (.18)	0% (.59)

CI: confidence interval; MA: meta-analyses; SMD: standardized mean difference; SR: systematic reviews.

Observational Studies

Singh and Losken (2012) reported on a systematic review of studies reporting outcomes after reduction mammaplasty. (17) In 7 studies reporting on physical symptoms (n range, 11 to 92 patients), reviewers found reduction mammaplasty improved functional outcomes including pain, breathing, sleep, and headaches. Additional psychological outcomes noted included improvements in self-esteem, sexual function, and quality of life. Torresetti et al. (2022) conducted another systematic review to examine the potential association between bilateral breast reduction and improvement in lung function in women with macromastia. (18) The review included 15 studies published from 1974 to 2018 (n range, 1 to 50 patients). The findings showed that reduction mammaplasty can lead to changes in objective respiratory parameters, such as spirometric tests or arterial blood gas measurements, but the clinical significance of these changes was unclear.

Hernanz et al. (2016) reported on a descriptive cohort study of 37 consecutive obese patients who underwent reduction mammoplasty for symptomatic macromastia, along with 37 age-matched women hospitalized for short-stay surgical procedures. (19) In the preoperative state, SF-36 physical health component subscore was significantly lower for patients with symptomatic macromastia (40) than for age-matched controls (53; p<.001), with differences in 5 of the 8 subscales. At 18 months postprocedure, there were no significant differences in any SF-36 subscores except the body pain subscale between patients who had undergone reduction mammoplasty and age-matched controls.

Kerrigan et al. (2002) published the results of the BRAVO (Breast Reduction: Assessment of Value and Outcomes) study, a registry of 179 women undergoing reduction mammaplasty. (20) Women were asked to complete quality of life questionnaires and a physical symptom count both before and after surgery. The physical symptom count focused on the number of symptoms present that were specific to breast hypertrophy and included upper back pain, rashes, bra strap grooves, neck pain, shoulder pain, numbness, and arm pain. Also, the weight and volume of resected tissue were recorded. Results were compared with a control group of patients with breast hypertrophy, defined as size DD bra cup, and normal-sized breasts, who were recruited from the general population. The authors proposed that the presence of 2 physical symptoms might be an appropriate cutoff for determining medical necessity for breast reduction. For example, while 71.6% of the hypertrophic controls reported none or 1 symptom, only 12.4% of those considered surgical candidates reported none or 1 symptom. This observation is difficult to evaluate because the study did not report how surgical candidacy was determined. The authors also reported that none of the traditional criteria for determining medical necessity for breast reduction surgery (height, weight, body mass index, bra cup size, or weight of resected breast tissue) had a statistically significant relation with outcome improvement. The authors concluded that the determination of medical necessity should be based on patients' self-reported symptoms rather than more objectively measured criteria (e.g., the weight of excised breast tissue).

Adverse Events

Thibaudeau et al. (2010) conducted a systematic review to evaluate breastfeeding after reduction mammaplasty. (21) After a review of literature from 1950 through 2008, reviewers concluded that reduction mammaplasty does not reduce the ability to breastfeed. In women who had reduction mammaplasty, breastfeeding rates were comparable in the first month postpartum to rates in the general population in North America.

Chen et al. (2011) reported on a review of claims data to compare complication rates after breast surgery in 2,403 obese and 5,597 nonobese patients. (22) Of these patients, breast reduction was performed in 1939 (80.7%) in the study group and 3569 (63.8%) in the control group. Obese patients had significantly more claims for complications within 30 days after breast reduction surgery (14.6%) than nonobese patients (1.7%; p<.001). Complications included inflammation, infection, pain, and seroma/hematoma development. Shermak et al. (2011) also reported on a review of claims data comparing complication rates by age after breast reduction surgery in 1192 patients. (23) Infection occurred more frequently in patients

older than 50 years of age (odds ratio, 2.7; p=.003). Additionally, women older than 50 years experienced more wound healing problems (odds ratio, 1.6; p=.09) and reoperative wound debridement (odds ratio, 5.1; p=.07). Other retrospective evaluations (2013, 2014) of large population datasets have reported increased incidences of perioperative and postoperative complications with high body mass index. (24, 25)

Section Summary: Reduction Mammaplasty for Macromastia-Efficacy in Reducing Symptoms
Systematic reviews of RCTs and observational studies have shown that several measures of function and quality of life improve after reduction mammaplasty.

Summary of Evidence
For individuals who have symptomatic macromastia who receive reduction mammaplasty, the evidence includes systematic reviews of randomized controlled trials, cohort studies, and case series. Relevant outcomes are symptoms and functional outcomes. Studies have indicated that reduction mammaplasty is effective at decreasing breast-related symptoms such as pain and discomfort. There is also evidence that functional limitations related to breast hypertrophy are improved after reduction mammaplasty. These outcomes are achieved with acceptable complication rates. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Practice Guidelines and Position Statements
American Society of Plastic Surgeons
In 2011, the American Society of Plastic Surgeons (ASPS) issued practice guidelines and a companion document on criteria for third-party payers for reduction mammaplasty, which was updated and reaffirmed in March 2021 and March 2022. (26, 27) Based on high quality evidence, the ASPS strongly recommends that "postmenarche female patients presenting with breast hypertrophy should be offered reduction mammaplasty surgery as first-line therapy over nonoperative therapy based solely on the presence of multiple symptoms rather than resection weight." The guideline goes on to state that "reduction mammaplasty surgery is considered standard of care for symptomatic breast hypertrophy." The companion document notes that medical records should document the symptoms associated with the hypertrophy the patient has experienced, and lists the following:

- "Documentation may include pain that patient experiences in the neck, back, or breasts related to movement
- Difficulties in daily activities such as grocery shopping, banking, using transportation, preparing meals, feeding, showering, etc.
- Documentation of any secondary complications or infections that may have occurred as a result of hypertrophy or macromastia including intertrigo, chronic rash, cervicalgia, dorsalgia, or kyphosis
- Documentation of prior procedures or therapies may be included but not required for approval
- Photographs demonstrating the patient’s breast appearance, possible shoulder grooves and kyphosis can be included in the medical documentation

- Significant scientific evidence supports non-operative therapies should not be required prior to approval of the procedure."

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers, a number of which have conditional coverage criteria for reduction mammaplasty. (28-30)

Ongoing and Unpublished Clinical Trials

A currently unpublished trial that might influence this policy is listed in Table 4.

Table 4. Summary of Key Trials

NCT Number	Trial Name	Planned Enrollment	Completion Date
NCT04889469	Indications for Breast Reduction in the Public Health Care System	2000	Aug 2031

NCT: national clinical trial.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	19318
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change

01/01/2026	Document updated. The following changes were made to Coverage: 1) Conditional criteria significantly revised without real change to intent; 2) Special Comment, NOTEs, and Documentation Requirements moved to Policy Guidelines section, 3) Medical necessity statement on staged reduction mammaplasty converted to EXCEPTION statement; 4) Revised experimental, investigational and/or unproven statement without change to intent; and 4) Removed experimental, investigational and/or unproven statement on liposuction. Added references 12-16 and 28-30; others removed. Title changed from: Reduction Mammaplasty.
12/01/2024	Document updated with literature review. The following change to coverage was made: Added "A staged reduction mammaplasty preceding a nipple sparing mastectomy or lumpectomy for breast cancer may be considered medically necessary in order to preserve the viability of the nipple." References 13, 21-23 and 25 added; others updated.
07/15/2023	Reviewed. No changes.
05/15/2022	Document updated with literature review. Coverage unchanged. Reference 20 updated.
01/01/2022	Added Note 3 to Coverage: Tissue removed that plots between the 5th and 22nd percentile of the Schnur Sliding Scale may be either cosmetic or reconstructive. Determination will be based on the review of the information provided.
07/01/2021	Reviewed. No changes.
08/15/2020	Document updated with literature review. Coverage unchanged. No new references added.
10/15/2019	Reviewed. No changes.
01/15/2019	Document updated with literature review. Coverage unchanged. No references added; one removed.
03/15/2018	Document updated with the following modification to Coverage: Changed from "Reduction mammaplasty is considered cosmetic and not medically necessary for the treatment of psychosocial indications or as a method to restore normal emotional functioning" to "Reduction mammaplasty is considered not medically necessary when the above criteria are not met, including but not limited to treating psychosocial symptomatology, psychosocial complaints related to appearance, or as a method to restore normal emotional functioning."
01/15/2018	Document updated with literature review. The following was added to the Coverage section: Photo Documentation Requirements: Photo documentation that is consistent with the physical exam findings of breast hypertrophy and shoulder grooving. The following was changed for failure of conservative measures, which states, "Failure of at least 6-weeks of conservative measures including." The following was removed from failure of conservative measures, "Anti-inflammatory agents unless medically contraindicated."

08/01/2016	Document updated with literature review. Coverage unchanged.
02/01/2015	Reviewed. No changes.
11/01/2013	Document updated with literature review. Coverage unchanged.
07/15/2009	Coverage revised by adding age limitation of age 18 for consideration if procedure is medically necessary. The word “comprehensive” was removed from coverage criteria.
02/01/2009	The following change(s) were made to Coverage criteria: Application of heat and cold compression as a symptomatic conservative therapy measure removed as a requirement to determine medical necessity.
04/01/2008	Policy reviewed without literature review; new review date only.
01/15/2008	Coverage changed
09/15/2006	Coverage changed
02/15/2006	Revised/updated entire document
09/01/2005	Revised/updated entire document
08/01/1999	Revised/updated entire document
05/01/1996	Medical policy number changed
01/01/1996	Revised/updated entire document
10/01/1994	Revised/updated entire document
06/01/1991	New medical document